## How to Complete the HCFA-1500 Claim Form

Refer to HRSA's current *General Information Booklet* for instructions on completing the HCFA-1500 claim form.

You may download this booklet from HRSA's website at: <a href="http://maa.dshs.wa.gov/download/Billing%20Instructions%20Web%20Pages/General%20Information.html">http://maa.dshs.wa.gov/download/Billing%20Instructions%20Web%20Pages/General%20Information.html</a> or request a paper copy from the Department of Printing (see *Important Contacts* section).

#### **Instructions Specific to Physicians**

Field	Instructions							
Number								
24B	See Section J for correct place of service codes. These are the only appropriate							
	place of service codes.							
24D	Enter the appropriate procedure code for the services being billed. See the fee							
	schedule in the Appendix. <i>Modifier</i> : When appropriate enter a modifier from the							
	list found in Section L.							
24H	When billing the department for one of the EPSDT screening procedure codes,							
	enter an <b>X</b> in this field.							

# How to Complete the HCFA-1500 Claim Form for Medicare Part B/Medicaid Crossovers

For services paid for and/or applied to the deductible by Medicare:

- Complete the claim form as if billing for a non-Medicare client.
- Always attach the Medicare EOMB.
- Enter **only** payments by a third party (e.g. Blue Cross) supplement plan in field 29 and attach the Explanation of Benefits (EOB).

**Note:** If you are billing for services Medicare has denied, you must use a separate claim form.

### **SAMPLE**

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1. MEDICARE MEDICAID	CHAMPUS	CHAMPV	A GROUP	FE	CA OTHER	1a. INSURED'S				(FOR P	PI ROGRAM IN	CA IITEM 1)	
(Medicare #) (Medicaid #)	(Sponsor's SSI	_	HEALTH PLA		K LUNG (ID)	MJ0701				(, 0,,,,	. 10 01 11 111 11	,	
2. PATIENT'S NAME (Last Name, First	Name, Middle Init	tial)	3. PATIENT'S BIRTH	Υ	SEX	4. INSURED'S	NAME (Last	Name, Fire	st Name,	Middle	Initial)		
SMITH, MARY, J	07 01 60	7. INSURED'S ADDRESS (No., Street)											
5. PATIENT'S ADDRESS (No., Street) 5555 NEVERENDING I	ROAD		Self Spouse	Child		7. INSURED'S	ADDRESS (I	vo., Street	:)				
CITY		8. PATIENT STATUS CITY					ST	ATE					
ANYWHERE	Single	Married _	Other										
ZIP CODE TELI 98000	EPHONE (Include	e Area Code)	Employed — Fu	ull-Time —	¬ Part-Time	ZIP CODE		TEI	LEPHON	E (INCL	UDE AREA	CODE)	
9. OTHER INSURED'S NAME (Last Na	me First Name N	10. IS PATIENT'S CO	11. INSURED'S POLICY GROUP OR FECA NUMBER										
		maaro milaliy				TH. INCOMED	or oblor ar	1001 011	LOTTIN	OWDER			
a. OTHER INSURED'S POLICY OR GR	ROUP NUMBER		a. EMPLOYMENT? (	CURRENT	OR PREVIOUS)	a. INSURED'S		RTH			SEX		
			b. AUTO ACCIDENT? PLACE (State)			j j M F							
b. OTHER INSURED'S DATE OF BIRTI MM   DD   YY	H SEX	F□	b. AUTO ACCIDENT	b. EMPLOYER	'S NAME OR	SCHOOL	NAME						
c. EMPLOYER'S NAME OR SCHOOL N			c. OTHER ACCIDEN		NO L	c. INSURANCE	PLAN NAM	E OR PRO	OGRAM N	NAME			
			YES	s [	NO								
J. INSURANCE PLAN NAME OR PROC	GRAM NAME		10d. RESERVED FO	R LOCAL I	USE	d. IS THERE A	NOTHER HE	ALTH BEI	NEFIT PL	_AN?			
BEAD BACK	OF FORM REF	ORE COMPLETIN	G & SIGNING THIS FO	RM.		YES 13. INSURED'S	NO NO		•		omplete iten		
12. PATIENT'S OR AUTHORIZED PER to process this claim. I also request p	RSON'S SIGNATU	JRE I authorize the	e release of any medical	or other info		payment of	medical bene scribed below	efits to the					
below.	sayment of govern	ment benefits entre	in to myself of to the party	y who acce	pto assignment	Services de	scribed belov	v.					
SIGNED			DATE			SIGNED							
MM   DD   YY   INJURY	S (First symptom) (Accident) OR	OR 15		F PATIENT HAS HAD SAME OR SIMILAR ILLNESS.				MM   DD   YY   MM   DD   YY					
7. NAME OF REFERRING PHYSICIAN	ANCY(LMP) N OR OTHER SO	URCE 17	a. I.D. NUMBER OF REI	FERRING	   PHYSICIAN	FROM TO TO 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES							
						MM   DD   YY							
9. RESERVED FOR LOCAL USE						20. OUTSIDE LAB? \$ CHARGES							
A DIAGNOSIO OD MATURE OF ILLNI	500 OD IN IIIDV	(DELATE ITEMO	100001701751401	(E.D.) (   INE	<u>-,                                      </u>	YES NO 22. MEDICAID RESUBMISSION							
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)					=) —	CODE CODE	RESUBMISS	ORI	GINAL R	EF. NO			
1. [461.0]	3	23. PRIOR AUTHORIZATION NUMBER											
2. 465.0			4										
24. A  DATE(S) OF SERVICE To	B Place	C Type PROCEDU	D IRES, SERVICES, OR S	SUPPLIES	E DIAGNOSIS	F	DA'	H YS EPSD	I T	J	RESERV		
From To  MM DD YY MM DD	of YY Service S	of (Expl	ain Unusual Circumstan		CODE	\$ CHARG	ES UNI	R Family TS Plan	EMG	СОВ	LOCA		
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j j j j 25. FEDERAL TAX I.D. NUMBER	SSN EIN	26. PATIENT'S	ACCOUNT NO. 2	27. ACCEP	PT ASSIGNMENT? rt. c <u>laim</u> s, see back)	28. \$ TOTAL C	HARGE	29. \$ AN	I MOUNT F	PAID	30. \$ BALA	NCE DUE	
				(For gov YES	NO		5000	L		L		5000	
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS  32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)					SERVICES WERE	33. PHYSICIAN & PHONE #		R'S BILLI	NG NAM	E, ADDI	RESS, ZIP (	ODE	
(I certify that the statements on the rapply to this bill and are made a part	( ) ( )			JAMES W WILLIAMS 1500 N MADISON									
	,					ANYTOW	/N WA 98	3926 (	360) 7	777-8	888		
SIGNED				PIN#			GRP#	1234	567				

### **SAMPLE**

TAPLE NITHIS REA  Medicare Crossover										
PICA			Н	EALTH INS	SURANCE CL	AIM FO	RM		PICA	
1. MEDICARE MEDICAID  (Medicare #) (Medicaid #)	CHAMPUS ( (Sponsor's SSN)	(VA File #)	SSN or ID) (S	CA OTHER K LUNG SSN) (ID)	1a. INSURED'S I.D. NU MJ070160SN		(1	FOR PROG	GRAM IN ITEM 1)	
2. PATIENT'S NAME (Last Name, First Na SMITH, MARY, J	ame, Middle Initial)	MM	OT'S BIRTH DATE  DD   YY  01   60 M	SEX F	4. INSURED'S NAME (	Last Name, Firs	st Name, I	Middle Initia	d)	
5. PATIENT'S ADDRESS (No., Street)			O1 60 M NT RELATIONSHIP TO		7. INSURED'S ADDRE	SS (No., Street)	)			
5555 NEVERENDING R	OAD	Self	Spouse Child	Other						
ANYWHERE		WA Sing	NT STATUS gle Married	Other	CITY				E AREA CODE)  X F	
ZIP CODE TELEF 98000	PHONE (Include Area Co	ode) Employ		Part-Time Student	ZIP CODE TELEPHONE (INCLUDE AR				E AREA CODE)	
9. OTHER INSURED'S NAME (Last Name	e, First Name, Middle Ini	itial) 10. IS PA	Student TIENT'S CONDITION	11. INSURED'S POLIC	Y GROUP OR I	FECA NU	MBER			
a. OTHER INSURED'S POLICY OR GRO	a. EMPLC	YES	a. INSURED'S DATE OF BIRTH  MM   DD   YY      M   F							
b. OTHER INSURED'S DATE OF BIRTH MM   DD   YY	SEX	b. AUTO	ACCIDENT?	PLACE (State)	b. EMPLOYER'S NAMI	E OR SCHOOL	NAME			
c. EMPLOYER'S NAME OR SCHOOL NA	M F	c. OTHEF	YES R ACCIDENT?	c. INSURANCE PLAN	NAME OR PRO	IGRAM N	AMF			
			YES	NO						
d. INSURANCE PLAN NAME OR PROGE	RAM NAME	10d. RES	ERVED FOR LOCAL	d. IS THERE ANOTHE	R HEALTH BEN	NEFIT PL	AN?			
READ BACK O	OF FORM BEFORE CO	MPLETING & SIGNIN	G THIS FORM.		YES NO If yes, return to and complete item 9 a-d.  13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize					
<ol> <li>PATIENT'S OR AUTHORIZED PERS' to process this claim. I also request pay below.</li> </ol>	ON'S SIGNATURE I au	thorize the release of a	ny medical or other infe		payment of medica services described	l benefits to the				
SIGNED			DATE		SIGNED					
14. DATE OF CURRENT:   ILLNESS (INJURY (APREGNAL)	6. 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION  MM   DD   YY  FROM   TO									
17. NAME OF REFERRING PHYSICIAN (	OR OTHER SOURCE	17a. I.D. NUME	BER OF REFERRING	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES  MM   DD   YY  FROM   TO   TO						
19. RESERVED FOR LOCAL USE		I			20. OUTSIDE LAB?	NO	\$ CHAF	RGES		
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DATE(S) OF SERVICE To	of of	ROCEDURES, SERV (Explain Unusual CPT/HCPCS   M		DIAGNOSIS CODE	\$ CHARGES	DAYS EPSDTORM OR Family UNITS Plan		COB R	ESERVED FOR LOCAL USE	
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25. FEDERAL TAX I.D. NUMBER	SSN EIN 26. PA	TIENT'S ACCOUNT N	(For gov	PT ASSIGNMENT? rt. claims, see back)	28. \$ TOTAL CHARGE		IOUNT PA	AID 30.	\$ BALANCE DUE 5000	
31. SIGNATURE OF PHYSICIAN OR SUI			YES  OF FACILITY WHERE	SERVICES WERE	33. PHYSICIAN'S, SUF		NG NAME	, ADDRES		
INCLUDING DEGREES OR CREDEN (I certify that the statements on the revapply to this bill and are made a part the	NDERED (If other tha	n home or office)	& PHONE #  JAMES W WILLIAMS 1500 N MADISON  ANYTOWN WA 98926 (360) 777-8888							

GRP# 1234567

APPROVED OMB-0938-0008